Vaginal Ovariotomy.

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VAGINAL OVARIOTOMY.*

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The cases of this operation already reported are comparatively so few that it seems advisable to put the following one upon record, at the same time comparing the operation with that by abdominal incision, as well as that by drainage of the cyst into the vagina with subsequent destruction of the cyst walls, a case of which I have published in the "Boston Medical and Surgical Journal."

Mrs. N. F. was kindly referred to me by Dr. T. G. Thomas. She was born in Poland, was twenty-five years of age, had been married six years, had had no children, but had one uncertain abortion two or three months after marriage, ever since which she had complained of more or less pain in the back and an occasional burning pain in the right groin. She could do very little work, any exertion or walking making the backache unendurable. She gave a very good family history; and her own health had usually been excellent, although she was not feeling very strong when she first consulted me, November 17, 1879. She had never been ill in bed. The catamenia appeared at the age of fifteen, and after the first year became regular. The flow lasted four or five days, its amount being equal to six thoroughly saturated napkins, with the discharge of some clots the first two or three days. Except a great increase of the backache, she suffered very little pain at that time. Much exertion caused a slight leucorrhœal discharge. Micturition had been rather frequent for a year, especially after walking. The bowels were regular. Physical examination showed the uterus pushed bodily forward toward the pubes and held there by a mass behind that organ of about the size of the fist. The uterus was normal in depth. In order to determine whether it was an outgrowth of the uterus or the ovary, a more complete examination under ether was necessary. This was accordingly made early in January, 1880, Dr. Davenport etherizing. The mass was then found to

* Read before the Boston Society for Medical Observation.

move free from the uterus, and to be connected with the left ovary or the left broad ligament. Soon after this Dr. Thorndike saw the case in consultation, and confirmed the diagnosis of cyst of the left ovary or broad ligament. As a possible means of cure, should it prove the latter, I advised aspiration of the mass, which was, however, delayed two months to allow any perceptible increase in size to determine the importance of immediate interference.

Examination on June 2d showed that the cyst had increased fully one third in size. It was accordingly aspirated *per vaginam*, without an anæsthetic, care being taken to wash out the vagina previously with a five per-cent. solution of carbolic acid, as well as to disinfect the aspirator with the same. Six ounces of sebaceous, fatty material were withdrawn, which completely solidified on standing. On removing the needle, two hairs were found in its eyelet. The contents were evidently those of a dermoid cyst. The patient was kept quiet for two days. As the pulse and temperature were normal, and she felt perfectly well, she was then allowed to get up, with permission after another day or two to resume her work, which was to assist her husband in a small dry-goods shop, and with the injunction to summon me if any untoward symptoms appeared. On June 18th, sixteen days after aspirating, I was sent for, and found that, for a week or ten days, the patient had suffered from frequent slight chills followed by fever, although she had persisted in her work during this time. The temperature was 100°. There was no special abdominal tenderness, but examination by the vagina revealed considerable behind the uterus. The cyst was undoubtedly suppurating. Its immediate removal was advised; but two days elapsed before consent to this was given, by which time the temperature had reached 102·5°. June 20th, assisted by Drs. J. W. Elliot, F. A. Smith, and C. P. Bancroft, Dr. Thorndike being present, the patient was etherized and placed on the left side; and, the Sims's speculum being introduced, the posterior cul-de-sac was opened by seizing the vaginal membrane with a tenaculum and carefully cutting through its thickness with scissors. A fact was here noticed which nearly always surprises the operator, i. e., the thickness of the tissues before reaching the peritoneal cavity, being in this instance fully three eighths of an inch. The incision into the peritonæum was enlarged to one inch and a half in the median line backward, care being taken not to wound the rectum. There was scarcely any hæmorrhage, and the cyst, which had nearly refilled, came into view through the incision. The finger, swept around it, found it free from adhesions. It was held down close to the vaginal incision with tenacula, while its wall was cut into and its contents evacuated. These were purulent, mingled with flakes of sebaceous and fatty matter and some hairs, rather offensive, although the odor was somewhat masked by the solution of carbolic acid, a stream of which was kept up upon the vaginal wound throughout the operation. The cyst wall was drawn through the incision, the pedicle ligated, and its extremity cauterized with the thermo-cautery. During the evacuation of the cyst, some of its contents unfortunately escaped into the peritoneal cavity, which was therefore thoroughly washed out, after the return of the pedicle, with a weaker solution of the disinfectant. A soft rubber drainage tube was inserted through the vaginal incision, its proximal end being left free just within the vulvar orifice. The operation lasted an hour and a half. Nine hours after the patient had been put to bed the temperature was 103°, and the pulse 116. She had reacted well, and considerable bloody serum was discharging through the drainage tube. On the second day there was scarcely any discharge, and the pelvic cavity was frequently washed out with a weak solu-

tion of carbolic acid. There being evidences of collapse, ether and brandy were given hypodermically; and, later in the day, morphia in the same way. The evening temperature being 104·2° and the pulse 126, and the symptoms of collapse having disappeared, a wet pack was ordered, to be renewed each twenty or thirty minutes. Half an ounce of champagne was given each fifteen minutes when awake. At 6 A. M. on the third day the temperature was 102° and the pulse 118, and the patient had slept considerably during the night. The wet pack was discontinued. On account of some vomiting, all nourishment and stimulants —beef-juice and brandy—were given by the rectum. The temperature remained most of the day between 101° and 102°. On the fourth day most of the nourishment, which consisted of Kent's alcoholic extract of beef, could be taken by the mouth and retained. At intervals of three or four hours considerable foul discharge containing fatty matter was washed out through the drainage tube. There was little variation of the temperature through the day from 102°, or of the pulse from 120. On the fifth day nourishment was well retained, and the injections through the tube returned clear, though slightly offensive. Twice during the day the temperature rose to 103°, and was each time reduced by the wet pack to 101°, where it remained for several hours. On the sixth day, despite the pack, it gradually rose to 104°, and the pulse to 140. Washing out the pelvic cavity, subcutaneous injections of brandy, quinine, or ether, were ineffectual to reduce the temperature and pulse, or to increase the strength of the patient, who died at noon of that day. No autopsy was allowed.

I was greatly indebted in the care of the case to Dr. Thorndike for valuable counsel, and to Dr. Elliot for unceasing practical assistance. I attribute the unfortunate result to septic peritonitis induced by the escape of a portion of the contents of the suppurating cyst into the peritoneal cavity, and my inability at the time of the operation thoroughly to cleanse that cavity through the vaginal incision. Every attempt was made to do this by careful sponging and syringing; but that it was not accomplished was evident from the washing out of some fatty matter as late as the fourth day.

In the case of the dermoid cyst previously referred to in this paper, I drained the cyst into the vagina, stitching the edge of the incised cyst to the edge of the vaginal incision, thus shutting off completely the peritoneal cavity from contact with the contents of the cyst, and finally destroying the whole interior of the latter in its shrunken state by the most thorough application of the thermo-cautery, made through the vaginal incision, the Sims's speculum being carried directly through it into the interior of the cyst. The patient made a perfect recovery. Three years have passed since the operation, and examinations made at intervals during this period give no evidence of any reforming of the cyst.

In both cases the cysts were dermoid, and their contents therefore highly irritating, increasingly so after suppuration had begun. In both, the cysts were about equal in size and behind the uterus,

pushing it forward toward the pubes, and in both were easily accessible by the vagina.

In the case where drainage without removal was depended upon, the peritoneal cavity was protected in the early part of the time by the stitches which completely surrounded the incision; and, later, when the interior of the cyst was suppurating, by the adhesions of the peritoneal surfaces in apposition, occasioned by the localized inflammatory action around the incision.

In the case where the cyst was removed, suppuration was undoubtedly excited by aspiration, and the contents of the cyst at the time of the operation were most irritating because of this suppurative action. In the attempt to evacuate into the vagina and draw the cyst walls through the vaginal incision, this irritating fluid found its way into the peritoneal cavity. That the remaining steps of the operation were successfully accomplished availed nothing. The irremediable harm had been done.

The success which now attends ovariotomy by abdominal incision renders the cases very few where removal by the vagina would be the better method, and I should limit it:

First, to cases where the cysts are small and their contents bland, so that removal can be effected without difficulty, and without great danger of septic peritonitis from the escape of any of the fluid into the peritoneal cavity.

Second, to dermoid cysts so small as to be removed through the vaginal incision without evacuation.

In the case of an ovarian cyst firmly adherent in the pelvis, I believe the best operation to be that of drainage into the vagina, with subsequent destruction by suppuration or by the cautery.